PCS *REVISED* QA Example Tool (Attachment D to Policy 3C) Instructions

Aspect of Care	Instructions
1. Performance Improvement Program	
1a. Agency (self-audit) record reviews are current and within policy guidelines	Reviewing the agency's QA file over the last service year, note if the self-audits are current by making sure they are completed **quarterly** (occurring or made at intervals of three months)Look at each quarter for the audit. If each quarter is , answer Yes. If not, answer No.
1b. Agency plan of correction (if indicated) is implemented	If issues are noted on the self-audit, are they backed up with a documented plan of correction? Reviewing the agency's QA file, note first if the agency has identified any deficits in their PCS program. If yes, then note that each issue has a plan of correction connected to the issue. If all agency identified issues have a plan of correction in place, answer Yes. If not, answer No.
1c. Agency complaint management system is current and implemented	Complaints are investigated and addressed in 72 hours. Look at agency complaint logs, forms or other QA type records. In some cases you may "discover" the complaint and it is not recorded. If there is no recording, ask the recipient if they had called or let someone know (other than the aide) they had a concern. If the agency failed to record a complaint, this is a No answer. If all complaints are addressed in 72 hours, answer Yes.
2. RN Assessment / Authorization for Services	
2a. PCS PACT documents medical condition related to need for PCS	In section 14 on PCS PACT, at least one <u>medical</u> diagnosis is noted and this diagnosis supports a need for Personal Care Services. Medications will also support the medical diagnosis. For example, if the client has HTN which is so debilitating they need assistance with personal care they should be on a medication to manage HTN. The medical diagnosis should be specified with an ICD-9 code. If there is a medical diagnosis with an ICD-9 code, answer Yes. If not, answer No.
2b. Deficits in activities of daily living (ADL) (mobility, eating, bathing, dressing toileting and ,continence) are supported by the medical condition and the assessment	Sections 19-24 on PCS PACT: at least 2 ADL deficits requiring hands-on assistance (score 2 or > in column A) are identified. The medical diagnosis/es in section 14 support/s both ADL deficits. If there are not 2 ADL deficits with a score of 2 or higher, answer No.
2c. Recipient rights reviewed and documented	Obtained on admission. Look for this to be noted on the consent to care

	or admission note. Also check if the DFS complaint line number (800 Care-line) was given to the recipient. If there is no documentation that the rights were reviewed or distributed, answer No.
2d. PCS PACT signed by physician within 60 days of the verbal or recorded order	Is the Physician signature date within 60 days of the verbal order date noted on page 4 of the PCS PACT? If the agency does not use the verbal order; they wait for the MD signature, make sure they have a signature before the first date of aide services. If there's no evidence of a verbal or recorded order, answer No.
2e. PCS PACT/assessment completed by PCS certified RN	The RN certification is on file for all RN's seeing client (AHEC connect certificate). The nurse signing the PACT and supervisory notes must have a certificate on file before any visits are made. If they have a certificate, answer Yes. If not, answer No.
3. Plan of Care	
3a. Days and hours are consistent with and based on identified needs (follows time and task guidance and exceptions are documented)	In the POC on page 4 of the PACT, are the hours noted for each task consistent with those put forth on the time guidance form? If yes, are exceptions to the time guidance documented in section 46 of PACT? If both are noted, answer Yes. If either is missing, answer No.
3b. Plan of care based on ADL deficits/identified needs/tasks and are included in the plan	Are the deficits on the assessment addressed in the POC? Are there tasks present in the plan of care to meet the scored criteria which qualified the client for services? Look for the "checks" in the third column on the ADL assessment, where the agency has identified the needs and then see if they are carried over to the plan of care. If the client has a "1" score in some areas and the need is indicated, the RN may allot some time to the activity, but it should be less than the maximum which is defined on the time and task guidance. If the time is consistent with the guidance, answer Yes. If not, answer No.
3c. Instrumental ADL (IADL) based on medical condition/ADLs/identified needs	Do the IADLs link to the ADLs noted in sections 27-31 on the PACT? Note the delegated medical monitoring tasks and other personal care tasks which are not qualifying ADLs are calculated in the ADL time. If the IADLs are consistent with the ADL deficits, answer Yes. If not, answer No.
4. Service Notes	
4a. Tasks in plan of care documented on daily service notes and any deviations to the plan or schedule are documented	Looking at the last month of service, does the in-home aide service log match the POC? The services logs/aide notes show the tasks done. Compare these to the plan of care. They should be reflections of each

	other. Are the reasons documented for the lapses/gaps in service/temporary changes "valid?" An invalid reason is one where the task is not completed because the recipient or other resource is consistently completing the task. If the logs and POC match with all deviations documented, answer Yes. If not, answer No.
4b. IADL tasks do not equal or exceed ADL tasks as documented on the daily service notes	Looking at the last month of service, if the in-home aide service logs document IADL tasks equaling or exceeding the time spent doing ADL tasks over the course of one week, answer No. If the documentation demonstrates the IADLs do not meet or exceed the ADLs, answer Yes.
4c. Times/days on service notes match plan of care/authorization and any deviations are documented	Services are provided as authorized. Compare PCS PACT/PLAN and actual service logs. Any/All deviations are documented. Examples of acceptable reasons for deviations include: MD, hospital, family visiting and will provide care, Holiday and family will provide care. Be wary of several instances where the only documentation = client did not feel well. If the hours/days on the service logs are the same as the PACT and deviations are noted, answer Yes. If not, answer No.
5. Service Management	
5a. Recipient satisfaction/perception of services documented	This is documented on the supervisory note and/or in the record. If found, answer Yes. If not, answer No.
5b. Supervision is timely (not to exceed 90 days and unplanned lapses)	Looking over the supervisory logs for the previous calendar year, count the dates between visits. If any are >90 calendar days apart, supervision is untimely. Unplanned lapses are 7 service days or less in length and acceptable excuses for being out of the 90 day sequence. An example of an excusable unplanned lapse would be an unplanned hospital admission. Look at the last year of supervision/service. If the time is 90 days or less in the last 4 cycles (or less if it is service provided less than a year), answer Yes. If not, answer No.
5c. Supervision meets standards: condition, continued service need, update plan as needs change	Does the note meet the criteria? The required elements of the supervisory note are: name of client, date of visit, RN time in & out of home, name and credentials of RN supervisor, type of visit, recipient evaluation, employee observation, ***noting recipient satisfaction (key aspect #5a),*** care plan review, & revision, if indicated based on identified needs. The critical aspects of the ***supervisory notes are: timely (Key aspect #5b),*** client condition is evaluated, client is assessed to continue to need

	the PCS services, the POC is noted as appropriate or updated, and is performed by a certified nurse. If the note meets the standard, answer Yes. If not, answer No.
5d. Follow up to complaints is conducted in accordance with Division of Facility Services (DFS) requirements and agency policy	Complaints are investigated and addressed in 72 hours. Review the agency complaint log to see if any incident of reported abuse, neglect, exploitation or misappropriation of property have been investigated and resolved. Identify a statement specific to satisfaction on the supervisory visit. If they have any dissatisfaction noted, look for the complaint documentation to measure the investigation. If no complaints have been filed by the recipient or all complaints are addressed per criteria, answer Yes. If not, answer No.
5e. Discharge/reason and needs noted	If the client has been discharged, look at the reason. If they have not been transferred to a skilled nursing facility, or deceased, ongoing care needs should be documented. If this is complete, answer Yes. If not, answer No.
5f. Discharge notice given (48 hours), if applicable	If the client was discharged, a 48 hour notice must be documented. If the agency has documented the client's preference/choice to waive the notice period or there is imminent danger for the staff or client (if danger is noted, a referral to APC/CPS should be documented), the 48 hour notice is not required. If the notice was applied as applicable, answer Yes. If not, answer No.
6. Finance/Billing	
6a. Services billed reconcile with authorized and provided services	Using the in-home aide service logs that correspond to the same dates, compare the dates and times. If any of the dates and times billed exceed the aide service log ,RN assessment or re-assessment times and RN supervision times, the claim is irreconcilable and the answer is a No. If all dates and times reconcile, answer Yes.
6b. Cost reports are complete and submitted timely to DMA	Is there a copy of the completed cost report submitted in the time frame (July 31)? If the agency has been in operation less than a year, they will not have a completed cost report. If yes, answer Yes. If not, answer No.
7. Medicaid Provider Enrollment	
7a. Authorization signature is current and on file with DMA	Look at your provider enrollment agreement. Is it signed by the current Administrator /responsible individual? Answer Yes or No.
7b. Changes in address/phone/leadership reported to DMA	Look at your provider enrollment agreement/updates. If you have had a

	change in address or phone, have you notified DMA provider enrollment? Is a copy of the notification in the file? If the documentation is present, answer Yes. If not, answer No.
7c. Individual provider number used for each licensed site	Look at the billing and PACT. Is this the billing number for the specific site correct? If yes, answer Yes. If the billing number for a different site was used, answer No.
8. System Performance	
8a. Division of Health Service Regulation (DHSR - formerly DFS) license is current and valid	DHSR : The Home Care license should be current, valid and posted in plain site of the general public. If it is, answer Yes. If not, answer No.
8b. Audits reviewed and in good standing or plan of corrections implemented, if applicable	Are there any state reviews, deficiencies in the agency? Is the corrective action plan implemented? If yes, answer Yes. If not, answer No.

Calculating Total Percentages (final column)	Calculate your total percentage by dividing the number of "yes" answers by the total number of answers. For example, out of 10 records, you have 9 "yes" and 1 "no," 9 divided by 10 equals 90%. If you had 7 "yes" and 3 "no" your total percentage is 70% (7/10 = 70%). For some of the aspects of care, you may have some n/a answers, such as when you are looking at an open record and there is no discharge notice or note (#5e & 5f). When calculating the total percentages where some records have an n/a answer like #5e or 5f, you do not count the n/a answers. For example, out of 10 records, 2 are discharged. You would have "yes" or "no" answers for 2 records and n/a for the other 8. When calculating your total percentage, you only count the 2 records. If both had "yes" answers, your total percentage is 100% (2/2 = 100%). If one had a "yes" and the other a "no" answer, your total percentage is 50% (1/2 = 50%).